ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

PERFORMANCE IMPROVEMENT SPECIFICATION MANUAL

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PERFORMANCE MEASURE

Access to Care: Appointment Availability for Routine Assessment

MINIMUM PERFORMANCE STANDARD

To improve client access to care by ensuring that routine assessments are available to clients within 7 days of referral a minimum of 85% of the time.

METHODOLOGY

Population
The population includes all TXIX/TXXI eligible adults and children who were referred for service during the measurement period. The T/RBHA referral logs specify TXIX/TXXI eligibility for all clients. Referral logs will specify population type (adult/child).

Data Source
The T/RBHAs provide their subcontractor referral logs to ADHS each month. The logs encompass data for all clients referred for routine behavioral health services.

Data Collection Timeline and Delivery
Referral logs are due to ADHS by the 22nd of each month for the previous month. For the last month of the quarter, referral logs are due to ADHS by the 15th of the month for the previous month. The following are the 4 reporting quarters: July through September, October through December, January through March, and April through June.

Referral logs are placed on the network server (Sherman Server) by the T/RBHAs in their specific subfolder in the BQMEFTP folder. Electronic files are submitted in Comma Delimited Text Format according to ADHS Access to Care Referral Log Specifications and Referral Log Column Layout requirements. Referrals that contain errors in fields required to calculate compliance are excluded from "valid" referrals.

A computer program calculates compliance with the performance measure electronically within 1-2 weeks. The calculation is based on total valid referrals. The results are placed on the Sherman Server in the T/RBHA subfolder. ADHS emails T/RBHAs notification to access the file.

Data Reporting
Monthly data is aggregated for quarterly reporting. The Access to Care/Appointment Availability Report is due to AHCCCS on the following dates (approximately 45 days after quarter end): November 15th, February 15th, May 15th, and August 15th.

A copy of the quarterly report is provided to each RBHA.

QUALITY CONTROL

To improve data quality and integrity, ADHS/DBHS electronically calculates the percentage of the Access to Care referral log errors on a monthly and quarterly basis and informs T/RBHAs of their percentage of errors.

ERROR RATE 5%

A maximum error rate of 5% is allowed on the accuracy and completion of referrals contained on monthly referral log submissions. ADHS will take formal action if the percentage of errors exceeds 5% for two consecutive quarters.

CONFIDENTIALITY PLAN

Referrals are submitted electronically to the Sherman Server. All data is kept in a locked area, only staff working on the performance measure have access to the files. Data collected for the access to care measure is used only for this project. Data for this measure has been preserved and will not be destroyed.

PERFORMANCE INDICATORS

The following performance indictor is used:

Percentage of Referrals Offered Appointments Within 7 Days of Referral Date (Routine Assessment)

Numerator: Number of Total Valid Referrals that meet the requirement of appointment availability (7 days).

Denominator: Total Number of Valid Referrals.

Results of the performance indicators will be compared with the AHCCCS/ADHS established standards for compliance, as follows:

Minimum:	85%
Goal:	90%
Benchmark:	95%

Routine Assessments Offered Within 7 Days of Referral
Referral Log Column Layout

Update Date: 10/12/05

Field Name	Definition	Format	Remarks
Title XIX/XXI	Eligibility at Referral.	Text: (1 character) Y, N, U Default: UNKNOWN	Y = Yes, N = No, U = UNKNOWN
Program Type	CHILD, SMI, GMH, SA, SED	Text: C, S, M, G, Z (1 character)	C = Child, S = SMI, M = GMH, G = SA, Z = SED If not enrolled, enter Child or GMH based on age.
Referral Source	Entity or person making referral.	Text: 2 characters Codes match the CIS demographic data definitions for "Referral Source"	01= Self/family/friend 03= Other behavioral health provider 19= Federal agencies (VA, HIS, federal prison, etc.) 35= AHCCCS health plan **and/or PCP** 36= CPS 24-hour urgent response (child) 37= Community agency other than behavioral health provider (homeless shelter, church, employer) 38= ADES (Other CPS, DDD, RSA) 39= ADE – Department of Education 40= Criminal justice/correctional (includes AAOC probation, ADOC, ADJC, Jail) 41= Other (anything not captured above)
Client Last Name		Text: 15 characters	
Client First Name		Text: 10 characters	
Date of Birth		Text: yyyymmdd (8 characters)	
BHS Client ID*	ADHS/BHS client ID number.	Text: 10 characters	
Referral Date	Date of referral/contact.	Text: yyyymmdd (8 characters)	
Date First Appointment Offered	Date of first offered appointment.	Text: yyyymmdd (8 characters)	
Date Appointment Scheduled	Date of actual appointment.	Text: yyyymmdd (8 characters)	
AHCCCS Provider ID	Agency providing service.	Text: 10 characters	Valid AHCCCS Provider ID

*This field is not mandatory and will not be considered when calculating error rates.

PERFORMANCE MEASURE

Emergency Appointments Available Within 24 Hours of Referral

MINIMUM PERFORMANCE STANDARD

To improve client access to care by making emergency services available to clients within 24 hours of referral a minimum of 85% of the time.

METHODOLOGY

Population
The population includes all adults and children requiring both immediate and urgent behavioral health responses from the RBHAs. This includes all Title XIX/XXI and non-Title XIX/XXI clients. In FY05, referral logs will also specify population type (adult/child).

Data Source
The RBHAs provide their RBHA/subcontractor referral logs to ADHS each month.

Data Collection Timeline and Delivery
Referral logs are due to ADHS by the 22nd of each month for the previous month. For the last month of the quarter, referral logs are due to ADHS by the 15th for the previous month. The following are the 4 reporting quarters: July thru September, October thru December, January thru March, and April thru June.

Logs can be sent via postal mail, in an email with a password-protected file, or put on the network server. If a file is put on the server, it is located in the RBHA folder on the server in an Access to Care subfolder. ADHS prefers pertinent information to access the file be sent in an email when the file is available. Electronic files are sent in Excel spreadsheets.

ADHS reviews the referral logs and pulls a sample within 1-2 weeks. The sample is sent to the RBHA electronically in a password-protected file or put on the server. If a file is put on the server, it is located in the RBHA folder on the server in an Access to Care subfolder. ADHS emails the RBHA all pertinent information to access the file. Electronic files are sent in Excel spreadsheets.

Data Reporting
Monthly data is aggregated for quarterly reporting. The Quarterly Contractor Performance Improvement Activity Report/Access to Care is due to AHCCCS on the following dates (approximately 45 days after quarter end):
November 15th
February 15th
May 15th
August 15th

SAMPLING METHODOLOGY FY05

The following represents the statistically significant sample size that will be used for FY05.

Sample Size
A statistically valid sample will be drawn for each GSA for both emergency service and routine assessment appointment availability. The sample size is determined using a 95% confidence level and a precision (margin of error) of +/- 5%.

FY05 Sample
The annual sample size is statistically significant and evenly distributed on a quarterly basis. The sample size is based on the total number of referrals reported by each GSA for FY04. The following chart outlines the FY04 annual referrals, the required sample size for FY05, and the required sample size per quarter.

	Number of Referrals	Sample Size FY05	
	FY04 Annual	Needed Annually	Needed Quarterly
CPSA-3	812	264	66
CPSA-5	5,161	360	90
EXCEL	1,022	280	70
NARBHA	4,839	356	89
PGBHA	7,835	368	92
VO	81,173	384	96

Monthly Sample
Clients are sampled by a systematic random sampling procedure using every *n*th. Monthly sample size number is obtained by distributing the quarter sample over 3 months.

The data elements recorded on the monthly sample for each RBHA include: Client Name/ID, Referral Date, Referral Time, Response Date, Response Time, Length of Time From Referral Date to Response Date, Calculation of the Time that Elapsed Between Referral Time and Response Time, the Calculation of the Percentage of Clients Sampled Who Were Offered an Emergency Service Within 24 Hours of Referral., and Provider Name.

QUALITY CONTROL

Initial RBHA submission of crisis service logs sometimes requires clarification or completion of sample data. ADHS provides assistance to the RBHAs to improve data collection and ensure final sample data is valid. ADHS reviews the completeness and accuracy of access to care data during the FY04 Administrative Review.

CONFIDENTIALITY PLAN

Referrals are submitted electronically through secure channels. All data is kept in a locked area, only staff working on the performance measure have access to the files. Data collected for the access to care measure is used only for this project. Data for this measure has been preserved and will not be destroyed.

PERFORMANCE INDICATORS

The following performance indictors is used:

Percentage of Appointments Available Within 24 Hours of Referral (Emergency Appointments):

Numerator: Number of sample referrals that meet the requirement for emergency appointments (within 24 hours of referral).
Denominator: Total number of sample referrals reviewed.

Results of the performance indicators will be compared with the AHCCCS/ADHS established standards for compliance, as follows:

Minimum:	85%
Goal:	90%
Benchmark:	95%

ERROR RATE 5%

A maximum of 5% errors on the accuracy and completion of sample referrals

Access to Care
Referral Log Specifications

Emergency Appointments Within 24 Hours
Referral Log Column Layout

Update Date: 10/12/05

Field Name	Definition	Format	Remarks
Title XIX/XXI	Eligibility at Referral.	Text: (1 character) Y, N, U Default: UNKNOWN	Y = Yes, N = No, U = UNKNOWN
Program Type	CHILD, SMI, GMH, SA, SED	Text: C, S, M, G, Z (1 character)	C = Child, S = SMI, M = GMH, G = SA, Z = SED If not enrolled, enter Child or GMH based on age.
Referral Source	Entity or person making referral.	Text: 2 characters Codes match the CIS demographic data definitions for "Referral Source"	01= Self/family/friend 03= Other behavioral health provider 19= Federal agencies (VA, HIS, federal prison, etc.) 35= AHCCCS health plan **and/or PCP** 36= CPS 24-hour urgent response (child) 37= Community agency other than behavioral health provider (homeless shelter, church, employer) 38= ADES (Other CPS, DDD, RSA) 39= ADE – Department of Education 40= Criminal justice/correctional (includes AAOC probation, ADOC, ADJC, Jail) 41= Other (anything not captured above)
Client Last Name		Text: 15 characters	Use UNKNOWN if client name not available
Client First Name		Text: 10 characters	Use UNKNOWN if client name not available
Date of Birth*		Text: yyyymmdd (8 characters)	
BHS Client ID*	ADHS/BHS client ID number.	Text: 10 characters	
Referral Date	Date of referral/contact.	Text: yyyymmdd (8 characters)	
Referral Time	Time of referral/contact.	Text: (8 characters) XX:XX ?M	Example: 05:30 PM
Date Service Provided	Date of response.	Text: yyyymmdd (8 characters)	
Time Service Provided	Time of response.	Text: (8 characters) XX:XX ?M	Example: 05:30 PM
AHCCCS Provider ID	Agency providing service.	Text: 10 characters	Valid AHCCCS Provider ID
Outcome	The resolution of the emergency.	Text	Example: Referral to Intake, Mobil Crisis, etc.

*These fields are not mandatory and will not be considered when calculating error rates.

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment
Methodology

Goal:
ADHS shall develop and implement policies and procedures to monitor the availability and timeliness of appointments, including routine appointments for ongoing services within twenty-three (23) days of assessment. The Routine Appointments for Ongoing Services Within 23 Days of Assessment measure indicates the percentage of clients that received a mental health service within twenty-three (23) days from assessment.

Performance Measure:
ADHS must meet, and ensure that each subcontractor meets the AHCCCS Minimum Performance standard. AHCCCS has established three levels of performance for percentage of clients that received a service for a mental health service within twenty-three (23) days from assessment:
Minimum Performance Standard at 85%
Goal at 90%
Benchmark at 95%

These performance measures are based on the percentage of usable data.

Data Stratification:

- Funding Source – Title XIX/XXI
- Population – Adults, Children

Reporting Specifications:

Timeframe: Quarterly
Lag Time: 3 month lag time
Data Source: Snapshot data for CIS System/EDS Intake table, 834 Enrollment/Disenrollment Transaction.

Definitions:

1. Assessment: The ongoing collection and analysis of a person's medical, psychological, psychiatric, and social condition in order to initially determine if a behavioral health disorder exists and if there is need for behavioral health services on an ongoing basis ensure that the person's service plan is designed to meet the person's (and family's) current need and long-term goals. The assessment date is obtained from the encounter data. The following codes are used to identify an assessment:

   CPT Codes: 90801, 90802, 90885, 96100, 96110, 96111, 96115, 96117, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275

   HCPCS Codes: H0002, H2000, H0031, (W4001, W4002, W4005, W4003)

   For purposes of this measure, an assessment must occur within 45 days of enrollment.

2. Encounter: A record of a covered service rendered by a provider to a client enrolled with a capitated RBHA on the date of service. Client assessment and first service information is derived from the encounter data. RBHAs have 210 days to submit encounter data to ADHS and 120 days to process pended encounter data. Lag time allows for the provider to submit the

encounter data to the RBHA and in turn submit the data to ADHS.

3. Enrollment: The measure includes an unduplicated count of newly enrolled Title XIX/XXI consumers during the dates of reference (quarter).

4. First Service: The first service is obtained from the encounter data. There are limitations on the type of billable service rendered within 23 days of assessment. The following comprehensive behavioral health service categories will be excluded as a first service on the same day as the initial assessment:

   A. 2. Assessment, Evaluation and Screening Services
   B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
   B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment
   C. 2. Laboratory, Radiology and Medical Imaging
   C. 4. Electro-Convulsive Therapy
   D. 1. Case Management
   D. 8. Sign Language or Oral Interpretive Services
   D. 9. Non-Medically Necessary Covered Services (Flex Fund Services)
   D. 10. Transportation
   G. 3. Mental Health Services NOS (Room and Board)
   I. Prevention Services

   Clients can get any covered service on the same day as the initial assessment, but only included services will count toward the performance measure.

   An assessment provided a minimum of one (1) day after the initial assessment could be used as a first service.

5. Usable Data: This includes members with an effective enrollment date during the reporting period having assessment encounter data within 45 days of enrollment. Members with usable data fall into one of two categories: 1. meeting the 23-day time standard; 2. not meeting the 23-day time standard. Members with usable data not meeting the 23-day time standard, either have encounter data, but the date of service is greater than 23 days after assessment, or have no additional encounter data.

6. Unusable Data: Includes members with an effective enrollment date during the reporting period with no assessment encounter data within 45 days of enrollment.

Methodology Calculate Measure:

1. ADHS establishes the total number of members enrolled with an effective enrollment date during the reporting quarter. ADHS receives the member enrollment information from the RBHAs, via the 834 Enrollment / Disenrollment Transaction. The member enrollment information is entered into the CIS system/EDS Intake table.

2. The performance measure has a minimum encounter data submission requirement consistent with Financial Operations. Appendix A outlines the minimum performance standards for usable data.

3. The percentage of Usable Enrollments is calculated. It represents the Number of Usable Enrollments/Total Number of Enrollments.

4. The percentage in compliance with providing a service within 23 days of assessment is based on usable data. The percentage of clients receiving a service within 23 days represents the Number of Usable Enrollments with a service within 23 days / Number of Usable Enrollments.

Appendix A: Minimum Performance Standards for Usable Data

Timeframe	How Measured	Minimum Performance Standard	Benchmark Performance Standard
Quarter 1 (July 1 – September 30)	Compare the number of members with an effective enrollment date during Quarter 1(July - September) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (July through September).	35%	70%
Quarter 2 (October 1 – December 31)	Compare the number of members with an effective enrollment date during the reporting quarter (October - December) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (October - December). Refresh the encounter data for the previous reporting quarter and restate Quarter 1 (July – September)	45%	75%
Quarter 3 (January 1 – March 31)	Compare the number of members with an effective enrollment date during the reporting quarter (January - March) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (January - March). Refresh the encounter data for the previous two reporting quarters and restate Quarter 1 (July – September) & Quarter 2 (October – December)	55%	80%
Quarter 4 (April 1 – June 30)	Compare the number of members with an effective enrollment date during the reporting quarter (April - June) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (April - June). Refresh the encounter data for the previous three reporting quarters and restate Quarter 1 (July – September), Quarter 2 (October – December), and Quarter 3 (January – March)	65%	85%
Annual Summary Annual summary FY 2004 due by March 1, 2005 180 –270 Days after year end	Annual Fiscal Year Summary. Compare the number of members with an effective enrollment date during each of the 4 quarters of FY04 (July 1, 2003 – June 30, 2004) with encounter data for an assessment, to the number of members with an effective enrollment data during each of the 4 reporting quarters (July 1, 2003 – June 30, 2004).	85%	85%

Enrollment – Penetration Protocol

A. PURPOSE:

To maintain a consistent method of identifying how many people have been served in the behavioral health system and the rate in which the system is meeting the needs of the community.

B. DEFINITIONS:

Behavioral Health Category: This is determined by the most current value within the Behavioral Health Category Code field in the Demographic Snapshot. However, the following age sub-definitions apply as determined by the client's age at the end date of reference:

- Child (Child) – Age must be 0 to less than 18
- Serious Mentally Ill (SMI) – Age must be 18 or greater
- Substance Abuse (SA) – Age must be 18 or greater
- General Mental Health (GMH) – Age must be 18 or greater
- Children's Medical Dental Plan (CMDP) – Age is not considered

Closed Eligibility Segment: An AHCCCS Eligibility record with an End Date greater than or equal to the start date of reference.

Closed Enrollment Segment: An enrollment segment with a Closure Date greater than or equal to the start date of reference.

Eligibility Category: This is determined by the value within the Contract Type field in the AHCCCS Eligibility Snapshot. If there was an eligibility segment at any time during the dates of reference, then the segment is selected. In order to determine CMDP Eligibility, the Contract Type value of "7" is used from the AHCCCS At Risk Snapshot. CMDP eligibility supersedes any other eligibility category.

Enrollment: The count of unduplicated consumers who had an intake record at any time during the dates of reference.

Open Eligibility Segment: This is an AHCCCS Eligibility record with a null value in the End Date field and a Start Date less than or equal to the end date of reference.

Open Enrollment Segment: This is an enrollment segment with a null value in the Enrollment Closure field and an Intake Date less than or equal to the end date of reference.

Penetration: The rate by which the number of Medicaid eligible consumers, as determined by AHCCCS, have been enrolled in the behavioral health system during the dates of reference (*Enrollment ÷ Eligible*).

Snapshot: This refers to a table created from the "live production" data as of a single point in time.

The AHCCCS 274 A thru H Summary Report: A report of Medicaid eligible consumers identified by their funding source (e.g. Title XIX, Title XXI, TANF, Prop 204, etc). The ADHS Office of Business Operations summarizes this report, which provides categorization by Title XIX Adult, Child, and CMDP and by Title XXI Adult and Child, Kidscare and HIFA II.

C. ENROLLMENT PROCEDURES:

1. Go to the most current Intake Table Snapshot, extract all intakes that have a valid intake date that is less than or equal to the end date of reference.
2. Join this extraction of all intakes from C1 to the most current Closure Table Snapshot. Define join using Contr_ID, Client_ID, and Intake Date.
3. From C2, extract enrollment records using the following Enrollment Closure hierarchy:
    i. Event Date from the Closure Table Snapshot where a valid Event Date is greater than or equal to the start date of reference. Assign Enrollment Closure Date = Closure.Event_Date
    ii. If there is no matching record in the Closure Table, then use the Closure Date from the Intake Table Snapshot where a valid Closure Date is greater than or equal to the start date of reference or is Null (blank). Assign Enrollment Closure Date = Intake.Closure_Date (if Intake.Closure_Date is Null, then substitute it with the end date of reference).
4. These are all potential enrollment segments. Join the enrollment segments from C3 to the CIS Primary Client Snapshot to define all enrollments under the Primary Client ID.

    Find all Primary Client Ids by defining the join as Enrollment.Client_ID = CISPrimaryID.Client_ID.
    Primary Client ID = CISPrimaryID.Primary_Client_ID
    Secondary Client ID = Enrollment.Client_ID
    If there is no matching CISPrimaryID record then,

Primary Client ID = Enrollment.Client_ID
Secondary Client ID = Enrollment.Client_ID

5. From extract C4, remove Dummy CIS Client Ids. Define join to Dummy Client ID Snapshot using Client_ID and Contr_ID.
6. From extract C5, select the most current enrollment segment based on the Primary Client ID. Define the most current Enrollment segment using the following hierarchy:
    i. Open enrollment segment
    ii. If there are only closed enrollment segments, select the closed segment with the maximum Enrollment Closure.
    iii. If there is more than one segment that meets criteria C6i or C6ii, next refer to the segment with the maximum CIS Add Date.
    iv. If there is more than one segment that meets criteria C6iii, next refer to the segment with the maximum Intake Date.
    v. If there is more than one segment that meets criteria C6iv, next refer to the segment with the maximum Change Control Date.

D. ELIGIBILITY CATEGORY PROCEDURES:

1. Join the Client Demographic Snapshot to the Primary Client ID Snapshot to define each Demographic record under the Primary CIS Client ID.

Find all Primary Client Ids by defining the join as Demographic.Client_ID = CISPrimaryID.Client_ID.
Primary Client ID = CISPrimaryID.Primary_Client_ID
Secondary Client ID = Demographic.Client_ID
If there is no matching CISPrimaryID record then,
Primary Client ID = Demographic.Client_ID
Secondary Client ID = Demographic.Client_ID

2. From extract D1, select the most current Demographic record for each client based on the Primary Client ID. Define the most current Demographic record using the Primary Client ID and the following hierarchy:
    i. Maximum Demographic Intake Date
    ii. If there is more than one segment that meets criteria D2i, next refer to the segment with the maximum CIS Add Date.
    iii. If there is more than one segment that meets criteria D2ii, next refer to the segment with the maximum Change Control Date.
    iv. If there is more than one segment that meets criteria D2iii, next refer to the segment with the maximum Transaction Code.

3. Join the AHCCCS Eligibility Snapshot to the AHCCCS ID Crosswalk Snapshot to find all Eligibility segments associated with the same client using the Primary AHCCCS ID. Select the Eligibility segments that have a valid Start Date less than or equal to the end date of reference and (a valid End Date greater than or equal to the start date of reference or End Date is null).

   Find all Primary AHCCCS IDs by defining the join as Eligibility.AHCCCS_ID = Crosswalk.Old_AHCCCS_ID.
   Primary AHCCCS ID = Crosswalk.New_AHCCCS_ID
   Secondary AHCCCS ID = Eligibility.AHCCCS_ID
   If there is not matching Crosswalk record then,
   Primary AHCCCS ID = Eligibility.AHCCCS_ID
   Secondary AHCCCS ID = Eligibility.AHCCCS_ID

4. Join extract from D3 to the Primary Client ID Snapshot to define each Eligibility segment under the Primary CIS Client ID.

   Find all Primary Client Ids by defining the join as Eligibility.Client_ID = CISPrimaryID.Client_ID.
   Primary Client ID = CISPrimaryID.Primary_Client_ID
   Secondary Client ID = Eligibility.Client_ID
   If there is no matching CISPrimaryID record then,
   Primary Client ID = Eligibility.Client_ID
   Secondary Client ID = Eligibility.Client_ID

5. From extract D4, select the most current Eligibility segment for each client based on the Primary Client ID. Define the most current Eligibility segment using the Primary Client ID and the following hierarchy:

   i. Open eligibility segment
   ii. If there are only closed eligibility segments, select the closed segment with the maximum End Date.
   iii. If there is more than one segment that meets criteria D6i or D6ii, next refer to the segment with the maximum CIS Add Date.
   iv. If there is more than one segment that meets criteria D6iii, next refer to the segment with the maximum Start Date.
   v. If there is more than one segment that meets criteria D6iv, next refer to the segment with the maximum Change Control Date.

6. Join the AHCCCS At Risk Snapshot to the AHCCCS SSN Crosswalk Snapshot to find all CMDP At Risk segments associated with the same client using the Primary AHCCCS ID.

   Find all segments under the old AHCCCS ID by defining the join as AtRisk.AHCCCS_ID = Crosswalk.Old_AHCCCS_ID.

Primary AHCCCS ID = Crosswalk.New_AHCCCS_ID
Secondary AHCCCS ID = AtRisk.AHCCCS_ID
If there is not matching Crosswalk record then,
Primary AHCCCS ID = AtRisk.AHCCCS_ID
Secondary AHCCCS ID = AtRisk.AHCCCS_ID

7. Join the AHCCCS Eligibility extract D5 with the At Risk extract D7 using the Primary AHCCCS ID field from both extracts.
8. Join the At Risk extract D8 with the Primary Client ID Snapshot to define each record under the Primary Client ID.

Find all Primary Client Ids by defining the join as AtRisk.Client_ID = CISPrimaryID.Client_ID.
Primary Client ID = CISPrimaryID.Primary_Client_ID
Secondary Client ID = AtRisk.Client_ID
If there is no matching CISPrimaryID record then,
Primary Client ID = AtRisk.Client_ID
Secondary Client ID = AtRisk.Client_ID

9. Since the AHCCCS Eligibility table can have multiple Client Ids for each AHCCCS ID, only the most recent Client ID needs to be associated to each At Risk record. Join the At Risk extract D8 with the most current Enrollment using the Primary Client ID.
10. Select the At Risk record that has an associated enrollment record based on the Primary Client ID.
11. Join all main extracts into one enrollment table based on the Primary Client ID.

Main Intake/Closure Extract (C6)
Main Demographic Extract (D2)
Main AHCCCS Eligibility Extract (D5)
Main At Risk Extract (D11)

12. Assign each Enrollment segment a new Behavioral Health Category (QM_BHC) and a new Eligibility Group (QM_ELIG) using the following “If-Then-Else” logic:

If At Risk Contract_Type = “7” then

QM_BHC = “CMDP” and

QM_ELIG = “T19-CMDP”

Else

If Eligibility ELG_GRP = “T19” or “DD” then QM_ELIG = “T19”

If Eligibility ELG_GRP = “T21” or “HI” then QM_ELIG = “T21”

If Eligibility ELG_GRP = Null (blank) then evaluate Eligibility Contract_Type as follows:

If Eligibility Contract_Type = “K” or “S” then QM_ELIG = “T19”
If Eligibility Contract_Type = “V” then QM_ELIG = “T21”
If Eligibility Contract_Type = “Anything Else” then QM_ELIG = “T19”

If there is no matching eligibility segment, then QM_ELIG = “NON”

If AGE < 18 and (Demographic Behavioral_Health_Category_Code = “Anything”

or *there is no matching Demographic segment)*, then QM_BHC = “Child”

If AGE => 18 and Demographic Behavioral_Health_Category_Code = “C” or “M” then

QM_BHC = “GMH”

If AGE => 18 and Demographic Behavioral_Health_Category_Code = “G” then

QM_BHC = “SA”

If AGE => 18 and Demographic Behavioral_Health_Category_Code = “S” then

QM_BHC = “SMI”

If AGE => 18 and (Demographic Behavioral_Health_Category_Code = “Anything

Else” or *there is no matching Demographic segment)*, then QM_BHC = “GMH”

End If

13. Counting enrollments is a process by which each client is placed in one distinct category and counted only once. Place each enrollment segment in the appropriate category based on QM_BHC (defined in D10) as follows:

    Child includes New_BHC = “Child”
    CMDP-Total includes New_BHC = ”CMDP”
    Non-SMI includes New_BHC = ”GMH”, “SA”
    SMI includes New_BHC = ”SMI”

14. Obtain the current RBHA Eligible counts from the ADHS Office of Business Operations - AHCCCS 274 A thru H Summary Reports. TRBHA Eligible counts are based on the At Risk Zip Code definitions provided by AHCCCS.
15. Penetration is determined by dividing the Enrollment counts (D11) by the Eligible counts (D12) within designated categories (defined in D11) as follows:

    Child Enrollment ÷ Child Eligibility
    CMDP Enrollment ÷ CMDP Eligibility
    Non-SMI Enrollment ÷ Adult Eligibility
    SMI Enrollment ÷ Adult Eligibility

Please refer to Flow Chart (Attachment A).

E. SPECIAL CASES:

1. Primary/Secondary CIS Client IDs (combine under Primary CIS Client ID)
2. Dummy CIS Client IDs (remove from enrollment extract)
3. Overlapping intakes at the same or multiple T/RBHAs with or without closure data.
4. Potentially valid Closure Table records without matching intakes may have been orphaned by previous processes.
5. Beginning in December 2004, AHCCCS began converting social security number IDs to an Alpha-Numeric ID. Therefore, the AHCCCS SSN Crosswalk Snapshot must be used to identify the Primary AHCCCS ID.
6. There are multiple Client IDs associated to the same AHCCCS ID in the AHCCCS Eligibility Snapshot table. Since the AHCCCS At Risk Snapshot table does not include a CIS Client ID, the Eligibility table is used to obtain the CIS Client ID and any multiple records based on Primary AHCCCS ID must be eliminated. The CIS Client ID is chosen from the most current Eligibility segment.

F. APPROVED BY:

Stuart M. Thomas Date

Bureau Chief, Bureau of Research and Data Dissemination

Arizona Department of Health Services
Division of Behavioral Health Services

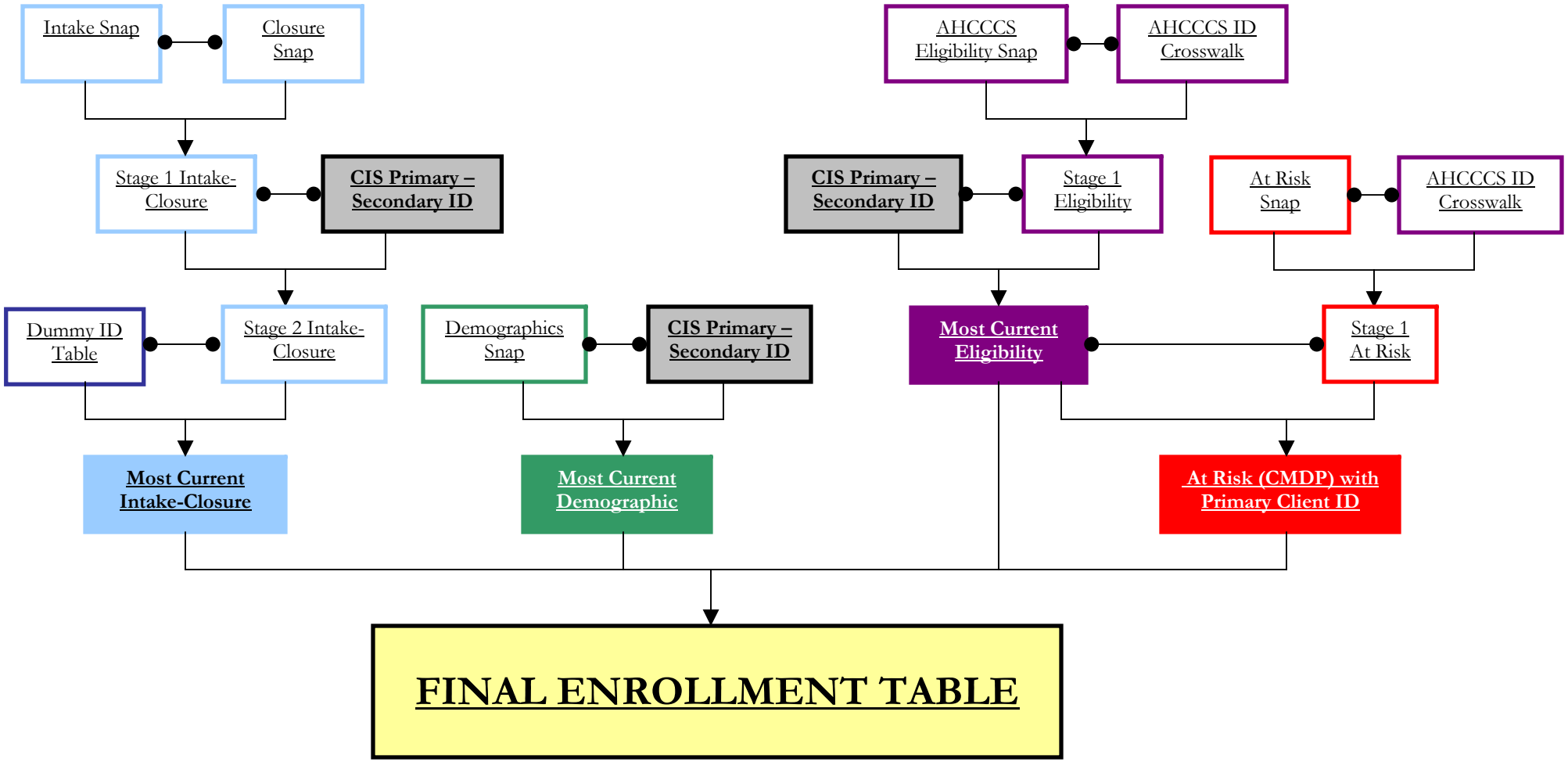
Sondra Stauffacher Date

Division Chief, Division of Quality Management Operations

Arizona Department of Health Services
Division of Behavioral Health Services

ATTACHMENT A (Updated: 08/01/2005)

ADHS/DBHS Enrollment Protocol Flow Chart
Used to determine BHC, Eligibility, Age, & Demographics



METHODOLOGY FOR 7 AND 30 DAY FOLLOW-UP MEASURE

HEDIS ELIGIBLE DISCHARGED CLIENTS (Denominator):

I. A. Start with base RBHA-submitted inpatient file.

II. A. Determine TXIX/XXI clients discharged during the quarter.
- Match by Client id against quarterly Enrollment table, pulling RBHA id, Client id, Admit date, Discharge date, Treatment setting, RBHA Fund Source, New RBHA Fund Source, SMI_SED, Contract type, Axis I and Axis II.
- If there is a (re)admission date same day as or one day following discharge date (transfer), it is considered one stay – remove first discharge.

III. A. Align discharged clients with HEDIS specifications for "eligible" population.

B. Remove from eligibles if:
- <6 years old,
- disenrolled within 30 days of discharge,
- did not have one of the following specific axis diagnoses: 295-299, 300.3, 300.4, 301, 308, 309, 311-314
- were admitted to a Level II facility within 30 days of discharge (W4051 & W4052 encounter codes)

C. Table will be duplicated on clients if they have multiple discharges occurring 30 days or more of each other. If multiple discharges occur within 30 days of each other, use only the last discharge.

IV. A. Fields required in table:

RBHA id	SMI_SED
Client id	Contract type
Admit date	Axis I_1
Discharge date	Axis I_2
Tx setting	Axis II_1
RBHA Fund Source	Axis II_2
New RBHA Fund source	

CLIENTS PROVIDED SERVICE AFTER DISCHARGE (Numerator):

I. A. Match Client Ids of clients discharged with clients in the CIS encounter file, pulling all encounters for the discharged clients where the encounter start date is after the discharge date or same date as discharge date only if the place of service is **not** an inpatient code.

B. Delete clients who had no encounter with service start date after discharge date.

C. Subtract date of service from date of discharge to calculate number of days after discharge service was provided.

II. For HEDIS measure:

A. Revenue codes to be included: 513, 900, 901, 909-916, 961.

B. Restrict to clients with encounter service codes listed:

90804	90806	90808	90810	90812
90814	90845	90853	90857	90847
90849	90801	90802	90885	99243
99244	99245	90805	90807	90809
90811	90813	90815	90862	99201
99202	99203	99204	99205	99211
99212	99213	99214	99215	99341
99342	99343	99344	99345	99347
99348	99349	99350	90870	90871
90816	90817	90818	90819	90821
90822	90823	90824	90826	90827
90828	90829	99241	99242	99383
99384	99385	99386	99387	99393
99394	99395	99396	99397	99401
99402	99403	99404	H0004*	

*Must have BHP modifier

III. For larger look at services being provided:

A. Restrict to clients with encounter service codes listed:

90804	90806	90808	90810	90812
90814	90845	90853	90857	90847
90849	90801	90802	90885	99243
99244	99245	90805	90807	90809
90811	90813	90815	90862	99201
99202	99203	99204	99205	99211
99212	99213	99214	99215	99341
99342	99343	99344	99345	99347
99348	99349	99350	90870	90871
90816	90817	90818	90819	90821
90822	90823	90824	90826	90827
90828	90829	99241	99242	99383
99384	99385	99386	99387	99393
99394	99395	99396	99397	99401
99402	99403	99404	H0004*	80299
90782	H0020	H2010	H2019	H2020
J0515	J1200	J1630	J1631	J2680
J3410	S0163	T1002	T1016	T1016
H0025	H0034	H0036	H0037	H0038
H2012	H2014	H2015	H2016	H2017
H2025	H2026	H2027	T1003	T1016
T1019	T1020			

*Must have BHP modifier

This measure is calculated for the percentage of clients discharged who received a service within 7 and 30 days of discharge. The measure is stratified by RBHA, Treatment setting, Contract type and Behavioral health category.

Frequency of report: Quarterly, with 90 day lag time. Each quarter, the current quarter is run and the previous 3 quarters are rerun in order to capture additional encounters.

Quality control checks:

1. Select a few of the client ids from “eligible population” table and research those clients in the enrollment table to confirm they have one of the “eligible” diagnoses and do not have a disenrollment date within 30 days of discharge date
2. Select a few of the client ids from the final table (after eliminating clients who did not have a “qualified” service code) and research those clients in the encounter table to confirm they received one of the “qualified” services.
3. For the 3 quarters that are rerun to capture additional encounters, confirm that the number of discharges remained the same and the number with a “qualified” service is the same as or greater than was previously reported.

/cd

INPATIENT UTILIZATION FILE

I. Objective

The objective of the 'Inpatient Utilization File' is to provide ADHS with inpatient utilization data. This data is intended to give a comprehensive view of several key indicators: Inpatient Days per 1000, Average Length of Stay, Readmission Rate, Percent and Hours/1000 of Clients Secluded and Restrained, and Follow-up Service After Discharge.

II. Reporting Frequency

The RBHA is required to electronically submit an Excel Inpatient Utilization Data Spreadsheet to ADHS Quality Management Department by the 30th day of the month following each quarter's end. Submission requirements include placing the File on the server in your RBHA's Inpatient Folder, and notifying the QM Department of submission and file name. Due dates are outlined as follows:

Time Period	RBHA Submission Date
January – March	April 30
April – June	July 30
July – September	October 30
October – December	January 30

III. Inpatient Utilization File Characteristics

1. The Inpatient Utilization File is a record of all RBHA enrolled T19/21 and Subvention clients admitted to a Level I Facility.

2. The admission and discharge fields on this file are the actual (physical) date of the member's admission and discharge, regardless of the dates for which the RBHA is financially responsible.

3. The Inpatient Utilization File is an aggregated record of inpatient utilization. That is, if a client is admitted on 3/20/03 and discharged 7/27/03 he/she will show in the following reporting periods: January – March, April - June, and July – September.

4. The Inpatient file includes:
   - Clients admitted to the Arizona State Hospital. In order to provide accurate admit and discharge dates, it may be necessary to reconcile the file of State Hospital clients at least quarterly.
   - DDD LTC clients.

IV. Required Field Characteristics

1. RBHA_ID

   Field Type: Text
   Field Description: The 2-digit RBHA ID

2. Client_ID

   Field Type: Text
   Field Description: This is the valid 10-digit CIS client ID #

3. AHCCCS_ID

   Field Type: Text
   Field Description: This is the 6-digit facility AHCCCS ID # assigned by AHCCCS. This file is an account of the facility the client is admitted to/discharged from, not individual providers such as Doctors.

4. Treatment_Setting
   Field Type: Text
   Field Description: This field is to be completed using **only one of the four (4) options specified below**:

Treatment Setting Option	Treatment Setting Description
ASH	This field is for Arizona State Hospital only.
INP	This field is for all inpatient settings which include Inpatient, Detox, and IMD.
SUB	This field is for all PHF and Subacute settings.
RTC	This field is for Residential Treatment settings only.

IMD, Detox, and PHF are not Treatment Setting options. However, they should be included in one of the four (4) specified Treatment Setting options listed above.

5. Admit_Diagnosis

   Axis -I-1

   Field Type: Character
   Field Description: ICD-9 Axis I Primary Medical Condition. Denotes clinical syndromes.
   Valid ICD-9 Code- 6-byte format is XXX.XX

   Axis - I-2

   Field Type: Character
   Field Description: ICD-9 Axis I Secondary Medical Condition. Denotes clinical syndromes.
   Valid ICD-9 Code- 6-byte format is XXX.XX

   Axis -1-3

   Field Type: Character
   Field Description: ICD-9 Axis I Tertiary Medical Condition. Denotes clinical syndromes.
   Valid ICD-9 Code- 6-byte format is XXX.XX

   Axis -II-1

   Field Type: Character
   Field Description: ICD-9 Axis II Primary Medical Condition. Denotes developmental and personality disorders.
   Valid ICD-9 Code- 6-byte format is XXX.XX

   Axis -II-2

   Field Type: Character
   Field Description: ICD-9 Axis II Secondary Medical Condition. Denotes developmental and personality disorders.
   Valid ICD-9 Code- 6-byte format is XXX.XX

   Axis –III

   Field Type: Character
   Field Description: Axis III

6. Admit_Date

   Field Type: Date

Field Description: This is the actual (physical) date the client is admitted. This date must be in the format 04/25/2003

7. Discharge_Date

Field Type: Date
Field Description: This is the actual (physical) date the client is discharged. This date must be in the format 09/05/2003.

If the client is not discharged during the current reporting quarter, then this field **must be left blank**.

In the case of clients discharged from the State Hospital, **the actual discharge date must be used** (not the date in which Title19 benefits end).

If a client is admitted and discharged on the same day, the inpatient file must reflect a one-day stay by documenting the discharge date the day after the admit date.

Inpatient Utilization File Quality Check Specifications

1. **Duplicate fields.** Example: client with multiple entries that are duplicated.

2. **Inconsistent admit/discharge date.**

   a. Same admit date with multiple discharge dates or same d/c date with multiple admit dates.
      - Example:

RBHA_ID	Client_ID	AHCCCS_ID	Treatment_Setting	Admit_Date	Discharge_Date
04	1234567891	123456	INP	5/1/2004	5/10/2004
04	1234567891	123456	INP	5/1/2004	6/30/2004

   b. Overlapping admit and discharge dates.
      - Example:

RBHA_ID	Client_ID	AHCCCS_ID	Treatment_Setting	Admit_Date	Discharge_Date
04	1234567891	123456	INP	5/1/2004	5/20/2004
04	1234567891	123456	INP	5/6/2004	6/30/2004

   c. Admission date later then discharge date.

   d. Same day admit and discharge date for the same row entry.

   e. Open discharge date prior to the latest admit date entry.
      - Example:

RBHA_ID	Client_ID	AHCCCS_ID	Treatment_Setting	Admit_Date	Discharge_Date
04	1234567891	123456	INP	5/1/2004	
04	1234567891	123456	INP	6/6/2004	6/30/2004

   f. Bedholds should be treated as a discharge.
      - Example:

RBHA_ID	Client_ID	AHCCCS_ID	Treatment_Setting	Admit_Date	Discharge_Date
04	1234567891	123411	RTC	5/1/2004	Bedhold
04	1234567891	123456	INP	5/10/2004	5/20/2004
04	1234567891	123411	RTC	5/20/2004	

Should be:

RBHA_ID	Client_ID	AHCCCS_ID	Treatment_Setting	Admit_Date	Discharge_Date
04	1234567891	123411	RTC	5/1/2004	5/10/2004
04	1234567891	123456	INP	5/10/2004	5/20/2004
04	1234567891	123411	RTC	5/20/2004	

3. **Client with open discharge date in prior quarter but not included on the current quarters inpatient file.**

4. **Level I Facility AHCCCS code, not individual provider AHCCCS code.**

5. **5% or more of the clients on the Inpatient file are not in CIS (No_Match).**

6. **All fields contain the appropriate characteristics.**

7. **Total volume of client entries from one quarter to the next change dramatically.**

8. **Other inconsistencies.**

INPATIENT UTILIZATION FILE QUALITY CHECK

Error Rate: <=8%. However, RBHAs will be required to correct any of the following errors found in the Inpatient File regardless of the number of errors.

RBHA: _____ Qu/Date: _____

Date Completed/Received Corrections: _____

Specifications *	Comments	# of Errors
1. Duplicated fields		
2. Inconsistent admit d/c date.		
a. Same admit date with multiple d/c dates or same d/c date with multiple admit dates.		
b. Overlapping admit and d/c dates.		
c. Admit date later then d/c date.		
d. Same day admit/discharge date.		
e. Open d/c date prior to latest admit date entry.		
3. Open d/c in prior Qu but not included on current Qu inpt. file.		
4. Facility AHCCCS code.		
5. No_Match (maximum error rate: <=5%)		
6. All fields contain appropriate characteristics.		
7. Total volume of client entries from one Qu to the next change dramatically.		
8. Other inconsistencies:		
	Total Errors ⇒	
Error Rate		
# of errors / # of total client entries		**%**

*Refer to document *'Inpatient Utilization File Quality Check Specifications'* for examples and explanations.

INPATIENT DAYS PER 1000

Definition:

Inpatient days is a count of the number of days all clients spent in an inpatient setting during the reporting period only. Client days prior to or after the reporting period are not included. Only the inpatient days incurred during the reporting period are included in the total count.

Methodology:

Number of Inpatient Days X 1000 = **Inpatient Days Per 1000**
Total Number of Enrollees

*I/S provides the **Inpatient Days** table using the following methodology:*

- **The number of patient days** for the reporting period is based upon the actual usage of days during the reporting period whether or not there is an admission date and/or discharge date in the quarter.
- For all members with an inpatient stay greater than 1 day, the number of days inpatient per member, per treatment setting is calculated by:
    - Subtract the admission date from the discharge date;
    - If the client has not been discharged, subtract the member's admission date from the last day of the reporting period;
    - If the client's admission date is prior to the first day of the reporting period, subtract the first day of the reporting period from the client's discharge date

(or last day of the reporting period).

*QM provides the **Enrollment Table** using the following methodology:*

- **The total number of Enrollees** is obtained from the CIS database. The I/S department makes available the enrollment tables for the reporting quarter. The total number of enrollees is recorded on the "Enrollment Distribution" document. The methodology for calculating the enrollment count includes:
    - Utilization of CIS data base;
    - Unduplicated count per RBHA, fund source, and contract type;
    - Enrollment date prior to the last day of the reporting period;
    - Disenrollment date is 'blank', or after the first day of the reporting period.

AVERAGE LENGTH OF STAY

Definition:

The average length of stay is the number of days from admission to discharge for each client discharged during the reporting period.

Methodology:

Total Number of Inpatient Days = **Average Length of Stay**
Total Number of Discharges

*I/S provides the **LOS** table using the following methodology:*

- Identify all clients discharged during the reporting period;
- Subtract the admission date from the discharge date to obtain the total number

of inpatient days per client (LOS).

READMISSION RATE

Definition:

The Readmission Rate has a 90-day lag time. All members discharged during the previous reporting period are assessed for a readmission within 30 days of discharge.

A readmission occurs when a client is admitted to the same or difference level of care within 30 days of discharge. The readmission rate applies to the treatment setting from which the client was discharged.

Methodology:

Number of clients readmitted within 30 days = **Percent of Readmission**
Number of Discharges

*I/S provides the **Readmits** table and the **Discharges_Prior** table using the following methodology:*

- Identify the members discharged from the previous quarter;
- Identify those members readmitted within 30 days of discharge;
- Transfers are not included. A transfer is considered a client who is admitted the same day or the next day following a discharge.

  - Example of transfers:

Discharge Date	Admit Date	
6/16/02	6/16/02	or
6/16/02	6/17/02	

  - Example of a readmission:

Discharge Date	Admit Date
6/16/02	6/18/02

- For those clients who are discharged in the last month of the quarter, the first month of the following quarter is used in the calculation.

SECLUSION AND RESTRAINT METHODOLOGIES

Definition:

Percent Of Clients Secluded (unduplicated)

Methodology: $\frac{\text{Total number of unduplicated clients who were secluded at least once during the reporting period } \mathbf{X}\ 100}{\text{Total number of unduplicated clients who were inpatient during the reporting period}}$

Definition:

Hours Per 1000 In Seclusion

Methodology: $\frac{\text{Total number of hours that all clients spent in seclusion } \mathbf{X}\ 1000}{\text{Sum of the daily census for each day (client days) in the reporting period } \mathbf{X}\ 24 \text{ hours}}$

Definition:

Percent Of Clients Restrained (unduplicated)

Methodology: $\frac{\text{Total number of unduplicated clients who were restrained at least once during the reporting period } \mathbf{X}\ 100}{\text{Total number of unduplicated clients who were inpatient during the reporting period}}$

Definition:

Hours Per 1000 In Restraint

Methodology: $\frac{\text{Total number of hours that all clients spent in seclusion } \mathbf{X}\ 1000}{\text{Sum of the daily census for each day (client days) in the reporting period } \mathbf{X}\ 24 \text{ hours}}$

Definition:

Percent Of Clients Pharmacologically Restrained (unduplicated)

Methodology: $\frac{\text{Total number of unduplicated clients who were pharmacologically restrained at least once during the reporting period } \mathbf{X}\ 100}{\text{Total number of unduplicated clients who were inpatient during the reporting period}}$

Definition:

Client Injury Events Per 1000

Methodology: $\frac{\text{Total number of client injury events during the reporting period } \mathbf{X}\ 1000}{\text{Total number of inpatient days during the reporting period}}$

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
BUREAU OF QUALITY MANAGEMENT AND EVALUATION

REPORTING SPECIFICATIONS

QUARTERLY SHOWING & STATISTICAL APPENDIX REPORT

I. RBHA submission of Showing Reports to ADHS

A. Each RBHA must submit a Quarterly Showing Certification signed by their Medical Director or CEO and a Statistical Appendix Format to ADHS as specified in the ADHS/RBHA contract. The report is due to ADHS by the **10th day of the month following the end of each reporting quarter**.

B. The Statistical Appendix should be in an Excel spreadsheet format and include their Title XIX/XXI clients who were in an acute/subacute psychiatric inpatient facility, Arizona State Hospital or Level I Residential Treatment Center and for whom a CON or RON was authorized during the reporting quarter. (Clients inpatient at Arizona State Hospital should be included for only the first 30 days of their stay and Long Term Care clients only if they are enrolled in a DD health plan.)

1. The Certification page is mailed or faxed to:
   Office of Utilization Management
   Bureau of Quality Management & Evaluation
   Arizona Department of Health Services
   Division of Behavioral Health Services
   150 N. 18th Avenue
   Phoenix, Arizona 85007
   Fax: (602) 364-4762

2. RBHAs submit the Statistical Appendix via their folder in the user's directory on the BHSW2K server or e-mail it as an attachment using PK Zip 5.0 and passworded. A hard copy of the Statistical Appendix is mailed to the Office of Utilization Management at the above address.

3. The Statistical Appendix is to include each Initial Certification of Need (CON) date and/or Recertification of Need (RON) date for a Title XIX or Title XXI client that occurred during the reporting quarter. Information relating to the CON/RON is to include: Client Last Name, Client First Name, AHCCCS id, CIS id, and Date of Birth.

4. Separate Excel spreadsheets should be submitted for Title XIX and Title XXI clients. If there are no Title XXI admissions for the quarter, include a Title XXI spreadsheet with "0" clients.

II. ADHS submission of Showing Report to AHCCCS

A. ADHS must report the findings of the Showing Reports to AHCCCS by the **17th day of the month following the end of each quarter**. This report includes:

1. Showing Report Findings that outlines the accuracy rate for each RBHA by Title XIX and Title XXI;
   Discrepancies between PMMIS and the RBHA reports are recorded as errors. There are two types of errors:
   * ID Errors – errors in the spelling of Last Name or First Name and errors in AHCCCS id or DOB.
   * Errors in Title XIX/XXI eligibility; where PMMIS reflects the client was not eligible on the date of the CON or RON.

2. The numbers of confirmed errors for each RBHA, ID errors and Eligibility errors, are entered into the Showing Report Findings table and the percentage of the total records submitted is calculated.

3. Copy of the signed Certification page for each RBHA.

4. Cover letter addressed to AHCCCS, signed by ADHS/DBHS Deputy Director and Medical Director.

B. Copies of the cover letter to AHCCCS and Showing Report Findings are mailed to each RBHA Executive Director.

/cd

REQUIREMENTS FOR SUBMISSION OF QUARTERLY SHOWING REPORT STATISTICAL APPENDIX

Due date: 10th day of the month following the end of each quarter. The report is to be submitted to ADHS electronically as well as hard copy.

Required fields:

1. **Last Name**
   Field Type: Text, upper case
   Field Description: As stored in the AHCCCS (PMMIS) database

2. **First Name**
   Field Type: Text, upper case
   Field Description: As stored in the AHCCCS (PMMIS) database
   Do not include middle initial

3. **AHCCCS id**
   Field Type: Text, 9 characters/digits
   Field Description: The id assigned by AHCCCS as stored in the AHCCCS (PMMIS) database

4. **Client id**
   Field Type: Text, 10 characters
   Field Description: Valid CIS client id as stored in the CIS database

5. **DOB**
   Field Type: Date, mm/dd/yyyy
   Field Description: As stored in the AHCCCS (PMMIS) database

6. **Initial CON Date**
   Field Type: Date, 4 digit year
   Field Description: Certificate of Need date for Level 1 facilities, Arizona State Hospital, inpatient subacute, RTC

7. **RON Dates**
   Field Type: Date, 4 digit year
   Field Description: Recertification of Need dates – minimum of 60 days
   For more than one RON for same client, add necessary number of columns, one for each additional RON

Notes:

1. Column for Health Plan No. should be eliminated.
2. If no permanent Client id has been assigned, assign a temporary unique client id; do not leave blanks in the Client id field.
3. When no information is applicable to a field, leave field blank; do not enter "N/A".
4. Do not add footnotes to the document (or footnote numbers in the name field). If additional information needs to be communicated, use a separate document.
5. Do not create a hard entry of column headings on pages subsequent to Page 1.
6. Do not separate pages by behavioral health category; submit one continuous report..
7. Title XIX and Title XXI entries should be submitted in separate reports.

Arizona Department of Health Services
SHOWING REPORT CHECKLIST

T/RBHA: _____ Reporting Quarter: _____
Date: _____

Issue	OK? (Y/N)	Comments
T/RBHA Submission		
1. Attestation page is received		
2. Standardized Attestation form is used		
3. Attestation page has correct dates reflecting current reporting quarter		
4. Attestation page is properly signed with signature dated		
Clerical		
1. Numbers & percentages on Showing Report Findings page are correct		
2. Numbers in letter to AHCCCS match those on Showing Report Findings page		
3. AHCCCS letter is signed by DBHS Deputy Director and Medical Director		
Data Interpretation		
1. Run Chart of number of records per RBHA		
2. Comparison of number of records to inpatient days		

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
MORTALITY REVIEW FORM: Children, SMI-Enrolled Recipients and Non-SMI Enrolled Recipients

ADHS DOCKET# _____ **DBHS OFFICE USE ONLY**

T/RBHA: _____ _____

Date of Report: _____ **Date of Death:** _____

I. CLIENT INFORMATION

Client Name: _____

Client ID#: _____ SS #: _____

Date of Birth: _____ Sex: Male _____ Female _____

Select One: Child ___ Adult SMI ____ Adult GMH/SA_____ _____ _____

Select One: TXIX TXXI Non-TXIX/XXI _____ _____

Marital Status: _____ Ethnicity: _____

Last Residence: Private Residence: _____ Alone: _____ W/Family: _____ W/Non Family: _____

Supported Housing: Alone: _____ W/Family: _____ W/Non Family: _____

Supervisory Care: _____ Arizona State Hospital: _____ Behavioral Health Facility: _____

Homeless: _____ Nursing Home/Hospice: _____ Jail: _____

Other (Please describe): _____

Date of Enrollment (Most recent date if multiple enrollment dates):

THE FOLLOWING SECTION DOES NOT REQUIRE COMPLETION IF THE REPORTED DEATH OF A NON-SMI BEHAVIORAL HEALTH RECIPIENT IS DUE TO A NATURAL CAUSE

TO COMPLETE THE FOLLOWING SECTIONS, THE ASSESSOR MUST REVIEW THE LAST 12 MONTHS OF THE MEDICAL RECORD

II. DEATH INFORMATION

Has the cause of death been determined? Yes _____ No _____

If no, please specify the date when autopsy will be completed: _____

If yes, please complete the following information:

Reported cause of death: _____

Did client commit suicide? Yes _____ No _____ Cannot Determine _____

Location of death: _____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Did the person have a history of suicide attempts? ☐ Yes ☐ No
If yes, describe any strategies used by the behavioral health practitioner or clinical team to prevent future attempts (attach a copy of the relevant documentation):

_____
_____
_____

Describe circumstances concerning the client's death up to 4 weeks previous, if relevant. Include statements made by client, family, witnesses, how you learned about the client's death, emergency interventions/services provided, and client's response to these services. (Must include substance abuse, significant loss, medical problems, and recent release from jail within the last 12 months, etc.).

_____
_____
_____
_____
_____
_____

Current Course of Treatment & Brief History:
Outline in chronological order the clinical course of behavioral health treatment over the past three (3) months (include information about client participation, intensity of case management and services, hospitalization, response to treatment, medication non-compliance, etc.).

Date	Service	Summary of Encounter/Participation/Outcome/ Mental Health Status

III. PSYCHIATRIC & PSYCHOSOCIAL INFORMATION

Psychiatrist/Prescriber (Name): _____

Date of last contact with Psychiatrist/Prescriber: _____

How long has this Psychiatrist/Prescriber been working with this consumer?_____

Date of last contact with Nurse: _____

Clinical Liaison (Name and Phone #): _____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Date of last contact with Clinical Liaison: _____

How long has this Clinical Liaison been working with this consumer: _____

Most Recent Psychiatric Dx: Axis I- Codes: _____

Axis II- Code: _____

Most Recent Medical Dx: Axis III Codes: _____

Current Medications (Psychiatric and Non-Psychiatric) – Type & Dosage:

_____

_____

_____

IV. MEDICAL INFORMATION

Primary Care Physician (Name): _____

Brief description of physical health one (1) year prior to death (include information about history of pain management treatment, frequent Emergency Department visits, and other specific issues that would impact health and the need to coordinate care with the Primary Care Physician):

_____

_____

_____

V. Reason Why Addendum Required:

☐ Suicide ☐ Homicide ☐ Drug overdose (prescribed or illicit)

☐ Accident ☐ Unexpected or unusual medical causes ☐ Request of ADHS/DBHS

☐ Not Applicable

VI. Was Corrective Action Taken? ☐ Yes ☐ No

If yes, please describe.

_____

_____

_____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Last Revision: 06/05/2006
Effective: 10/01/2006

MORTALITY REVIEW ADDENDUM

1. Did the person have family members involved with his or her behavioral health care? □ Yes □ No
   If yes:
   a. Describe what information was obtained from family members/guardian in terms of history of symptoms and treatment; early signs of decompensation; typical course of decompensation:

   _____

   _____

   _____

   b. Describe what information obtained from family members/guardian was incorporated in the treatment approach used by the behavioral health practitioner or clinical team:

   _____

   _____

   _____

   c. Describe what information/education was provided to family members/guardian with the enrolled person's consent or to the extent allowed by state law:

   _____

   _____

   _____

2. Did the person have co-occurring substance abuse issues? □ Yes □ No

   If yes, describe the treatment services that were offered/received that specifically addressed the substance abuse and the outcomes of such treatment:

   _____

   _____

   _____

   _____

3. Was the person adhering to treatment recommendations (taking medication as prescribed, attending appointments, etc.)? □ Yes □ No

   If no, please explain, including engagement and outreach efforts, clinical team communication/decision making, and if petition/amendment was considered when appropriate:

   _____

   _____

   _____

   _____

   If yes, describe what steps were taken to ensure the person received needed treatment. Were there any identified unmet needs?

   _____

   _____

   _____

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4. Did the person experience troublesome symptoms or side effects of medication that interfered with his or her ability to function? □ Yes □ No

   If yes, describe what steps were taken to improve the person's status or overall ability to function:

   _____

   _____

   _____

5. Had the person been discharged from an inpatient or residential setting within 30 days prior to the death? □ Yes □ No

   If yes, describe what steps were taken to ensure that coordinated discharge planning with the clinical team occurred and the person's needs were adequately met in the lower level of care:

   _____

   _____

   _____

6. SMI Behavioral Health Recipients: Did the person have co-occurring medical conditions, requiring medical care? □ Yes □ No

   a. If yes, describe actions taken by the behavioral health practitioner or clinical team to coordinate medical care:

   _____

   _____

   _____

   b. If no medical practitioner, describe actions taken by the behavioral health practitioner or clinical team to obtain needed medical care:

   _____

   _____

   _____

7. Is the cause of death still under review? □ Yes □ No

   If yes, please specify the date when investigation will be completed: _____

Name & Title of Person Preparing Report:

Signature Title Date

Name and Title of T/RBHA Person completing clinical/medical review, when indicated:

Signature Title Date

T/RBHA Medical Director or Designee:

_____

Signature Date

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